

SPECIAL 2007 STATE of the MHS CONFERENCE EDITION



US DEPARTMENT OF DEFENSE PATIENT SAFETY PROGRAM NEWSLETTER



JANUARY / FEBRUARY 2007

A QUARTERLY NEWSLETTER TO ASSIST THE MILITARY HEALTH SYSTEM IMPROVE PATIENT SAFETY

2006 PATIENT SAFETY AWARDS

The Department of Defense (DoD) and the Patient Safety Program (PSP) are committed to creating a culture of safety and quality care within the Military Healthcare System (MHS). Presentation of the annual DoD Patient Safety Awards at the State of the Military Health System Conference has become a tradition, and it is an opportunity to give public recognition to the extraordinary leadership, innovation and collaboration that characterize efforts to sustain and improve safety across the spectrum of military medicine.

The focus of the 2006 Patient Safety Awards is on *Innovation* and *Development* of systems and processes related to the needs of our patients. Within these broad guidelines, categories for awards include: Improvements to Team Performance; Innovative Approaches to Meeting National Patient Safety Standards; Use of Technology to Improve Patient Safety; Implementation of System Changes or Interventions to Improve Patient Safety; and for new initiatives that do not fit the above categories, Innovative Solutions.

"*Transforming Strategy Into Action: Partners in Excellence*" is the theme of the 2007 MHS Annual Conference. The 2006 Patient Safety Awards align seamlessly with this year's conference goal. They showcase the transformative power of innovation and development to improve delivery of care and patient safety. As the MHS Conference provides the opportunity to share knowledge and best practices, the Patient Safety Program is proud to share these outstanding award winning efforts.

Recipients of the 2006 Patient Safety Awards are:

- **60th Medical Group – David Grant Medical Center – Travis AFB, CA (Team Performance)**
- **Winn Army Community Hospital – Fort Stewart, GA and Martin Army Community Hospital – Fort Benning, GA (Innovative Approaches to Meeting National Patient Safety Goals)**
- **959th Surgical Operations Squadron/59th Medical Wing – Lackland AFB, TX (Technology)**
- **Evans Army Community Hospital – Fort Carson, CO (Implementation of System Changes)**
- **79th Medical Group – Andrews AFB, MD (Innovative Solutions)**

Improvements to Team Performance

60th Medical Group

Title: Sustainment and Reinforcement of TeamSTEPPS®

The 60th Medical Group, reacting to a Root Cause Analysis indicating widespread frustration with a perceived lack of communication as a team, committed to train all assigned medical personnel with clinical team skills and tools, and to develop a process to sustain teamwork training.

Leadership funded and trained thirteen personnel in the TeamSTEPPS® Train-the-Trainer course. The two-hour TeamSTEPPS® Essentials course was incorporated into the newcomers briefing, resulting in 94% of personnel trained. Over 1,650 high risk/high volume clinical area personnel attended the four-hour TeamSTEPPS® Clinical course. To insure

sustainment, a Simulation Lab to evaluate clinical and TeamSTEPPS® skill scenarios was developed.

The impact of this impressive commitment of time, personnel and funding to improve team strategies has been immediate and impressive. As of October, no Sentinel Events have been reported at the 60th Medical Group in 2006, and "harm to patient" incident reports are 12% lower than reported in 2005. Communication openness has significantly increased, as measured by comparing staff responses to related questions on the 2005/2006 Tri-Service Survey on Patient Safety with staff responses to an August 2006 follow-up. The Simulation Lab has been enhanced with three additional simulators. Leadership keeps the focus on patient safety and communication with a Patient Safety Coin award, Patient Safety Hall of Fame and

periodic patient safety promotions.

Innovative Approaches to Meeting National Patient Safety Standards

Winn Army Community Hospital and Martin Army Community Hospital

Title: A Human Systems Approach Using a Standardized Mnemonic Designed to Optimize the Quality and Continuity of the Patient Handoff Experience

Especially noteworthy as the first collaborative patient safety award initiative, the BSTAR mnemonic for patient handoffs developed by Winn ACH and Martin ACH arose from the demands of their unique patient care environments: the Patient Safety Managers had a history of problem-solving and working together, both faced the JCAHO mandate to implement a standard-

Continued on Back

Patient Safety Awards

Continued from Front

ized approach to handoff communications by January 1, 2006, but were challenged in this task by the war-time operational tempo and frequent staff rotations in both hospitals.

Determined to utilize their joint resources, the Patient Safety Managers, acting as team leaders, designed a methodology that included brain-storming sessions in each facility, reviews of current literature, and consideration of the existing mnemonics SBAR and I PASS the BATON. Ideas, models and feedback were shared regularly. When the handoff team at Winn ACH cross-walked the components of existing mnemonics and suggested BSTAR (background, situation, treatment, assessment and recommendations), both teams recognized a model that met their key criteria – not too long, not so short that it omitted key information, systematic in describing the patient and acceptable to the clinical staff, thus ensuring its use and sustainability.

Implementation of the new mnemonic has been a joint effort, as well. ICU nursing staff from both hospitals refined the BSTAR template, the clinical policy on handoffs is shared, and specialty units from Winn and Martin are working together to develop a BSTAR patient handoff document. Results have been two-fold — an efficient, replicable handoff mnemonic uniquely suited to today's operational tempo, and the satisfaction of a multi-disciplinary, collaborative effort between independent facilities who are united in their commitment to patient safety.

Use of Technology to Improve Patient Safety

**959th Surgical Operations Squadron/
59th Medical Wing**

Title: EM3: New Innovation for Patient Care/Safety Tracking in Emergency Department Settings

The extremely busy Emergency Department (ED) at Wilford Hall Medical Center, the only Air Force Level I Trauma Center, has been hampered by a computer system unable to adequately track and deliver patient information in real time with resulting inefficiencies related to triage, patient movement and follow-up. ED staff, with the invaluable expertise of an in-house Information Technology consultant, developed a software program that could adequately track patient status, placement, acuity, lab and radiology results, flag consults and critical results, and

display patient triage and movement throughout the system.

The EM3 system, which was created locally at minimal cost, has transformed the Wilford Hall Emergency Department. Using strategically-placed flat screen monitors, staff can now see at a glance which beds are occupied, their color-coded triage categories, the status of lab results and consults. The instant notification of critical value returns alone has made a dramatic difference, decreasing time from result to physician awareness from 5-30 minutes to zero minutes. A code for housekeeping automatically indicates when a bed is ready for cleaning, dramatically decreasing bed turnaround-time. In addition to real-time monitoring, the new system produces a daily report for leadership, as well as a daily report on patients that leave the ED without being seen, allowing them to be contacted and properly referred.

The impact of this innovative initiative will be felt well beyond Wilford Hall. EM3 has been demonstrated to other emergency departments, and may become part of the new DoD-wide AHLTA system. In the meantime, staff at Wilford Hall enjoy a new level of efficiency, and patients are both safer and more satisfied with their ED experiences.

Implementation of Systems Changes or Interventions to Improve Patient Safety

Evans Army Community Hospital

Title: Medication Management System

Initiative: System Overrides

Evans ACH took a proactive approach to patient safety in designing a Failure Mode Effects Analysis (FMEA) to review and assess its medication administration process, with a focus on medication overrides. Aware that overrides pose a significant risk to patient safety in general, but lacking data on their local impact, a team was assembled to conduct a FMEA that specifically addressed point-of-use (POU) dispensing machines and administrative medication overrides on inpatient wards.

The resulting FMEA went well beyond assessment, to include identification of root causes and rationales for committing overrides, as well as development of sustainable solutions to decrease or eliminate them. The team found that 33% of medications administered monthly were overridden for reasons ranging from human factors to system faults in the POU machines. The analysis showed no adverse drug results attributable to overrides. Although only eleven

medication errors originated as overrides, even this fairly minimal number revealed a weakness in the system, especially with respect to the Medication Reconciliation National Patient Safety Goal.

Based on the FMEA, Evans implemented new action plans to reduce the allowable rate of overrides to 5%. Staff training, coupled with Pharmacy coordination and process redesigns produced immediate results. New, more reliable POU machines contributed to an additional significant reduction in overrides, allowing the 5% goal to be sustained. The experience of Evans ACH highlights the importance of a systems approach to patient safety assessment, proving that even a seemingly adequate system can be improved when looked at as a whole.

Innovative Solutions

79th Medical Group, Andrews AFB

Title: Ad Hoc Report on Unreviewed Results

Andrews AFB became aware that there were large numbers of unreviewed results in its Composite Health Care System (CHCS). As in most hospitals, this went unnoticed until it was questioned during a JCAHO survey. Although not linked to any specific patient safety events, the risk inherent in this situation was immediately recognized, and a solution was sought.

The Unreviewed Results Ad Hoc Report was developed at Andrews using software already in place there. The project was designed by a CHCS system specialist and the clinical risk manager. Using a trial and error approach, they identified the data needed to support ad hoc reporting: provider status, ordering provider, location, patient name and SSN, test collected, date/time and results, with a flag on abnormal values.

Implementation presented the challenge of focusing staff attention on the necessity to act on heretofore overlooked data. With the assistance of the weekly ad hoc report, providers are no longer left to their own devices. The clinical risk manager now directly notifies providers who have unreviewed results, prompting them to attend to this outstanding issue.

Results of this deceptively simple project prove its efficacy. The number of unreviewed results has dropped dramatically, the data also can be used to track unsigned orders, and feedback has been universally positive. Concomitant follow-up provided to patients has improved, making Andrews a safer, as well as more efficient, environment.